FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036533

Facility Name: Willow Crest Nsg. Pavilion

Address: 515 North Main (Number) Sandwich (City) 60548 (Zip Code)

County: Dekalb

Telephone Number: (815) 786-8426 **Fax #** (815) 786-6487

IDPA ID Number: 363718794001

Date of Initial License for Current Owners: 01/11/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Richard S. Sgarlata, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	58	Skilled (SNF)	58	21,228	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,228	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,456	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,729	3,336	5,319	11,384	8
9	SNF/PED					9
10	ICF	16,483	5,904	357	22,744	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,212	9,240	5,676	34,128	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.38%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/1/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/1/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 4,650

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	178,535	19,436	7,824	205,795		205,795		205,795			1
2	Food Purchase		145,167		145,167	(16,013)	129,155	(391)	128,764			2
3	Housekeeping	78,342	19,369		97,711		97,711		97,711			3
4	Laundry	43,711	17,794		61,505		61,505		61,505			4
5	Heat and Other Utilities			108,313	108,313		108,313	770	109,083			5
6	Maintenance	61,005	43,601	32,746	137,352		137,352	4,754	142,106			6
7	Other (specify):*							492	492			7
8	**TOTAL General Services**	361,593	245,367	148,883	755,843	(16,013)	739,831	5,625	745,456			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,290,384	45,591	96,495	1,432,470		1,432,470	(698)	1,431,772			10
10a	Therapy		282		282		282		282			10a
11	Activities	58,311	4,918	3,431	66,660		66,660		66,660			11
12	Social Services	44,392		2,157	46,549		46,549		46,549			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,393,087	50,791	103,283	1,547,161		1,547,161	(698)	1,546,463			16
	C. General Administration											
17	Administrative	88,229		49,000	137,229		137,229	41,880	179,109			17
18	Directors Fees											18
19	Professional Services			309,998	309,998	(5,000)	304,998	(243,638)	61,360			19
20	Dues, Fees, Subscriptions & Promotions			76,523	76,523		76,523	(61,538)	14,985			20
21	Clerical & General Office Expenses	20,586	4,068	33,967	58,621		58,621	32,456	91,077			21
22	Employee Benefits & Payroll Taxes			276,612	276,612	16,013	292,625	(508)	292,117			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,110	3,110		3,110	448	3,558			24
25	Other Admin. Staff Transportation			2,546	2,546		2,546	(1,093)	1,453			25
26	Insurance-Prop.Liab.Malpractice			69,541	69,541		69,541	(5,222)	64,319			26
27	Other (specify):*							22,145	22,145			27
28	**TOTAL General Administration**	108,815	4,068	821,297	934,180	11,013	945,193	(215,070)	730,123			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,863,495	300,226	1,073,463	3,237,184	(5,000)	3,232,184	(210,143)	3,022,041			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Willow Crest Nsg. Pavilion #0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			137,025	137,025		137,025	76,894	213,919			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,506	18,506		18,506	103,549	122,055			32
33	Real Estate Taxes			57,388	57,388	5,000	62,388	2,732	65,120			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			4,295	4,295		4,295	5,684	9,979			35
36	Other (specify):*											36
37	**TOTAL Ownership**			697,214	697,214	5,000	702,214	(291,141)	411,073			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	142,100	134,379		276,479		276,479	(8,654)	267,825			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,684	63,684		63,684		63,684			42
43	Other (specify):*	23,292			23,292		23,292	(23,292)				43
44	**TOTAL Special Cost Centers**	165,392	134,379	63,684	363,455		363,455	(31,946)	331,509			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,028,887	434,605	1,834,361	4,297,853		4,297,853	(533,230)	3,764,623			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(26,357)	30		9
10	Interest and Other Investment Income	(14,606)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(391)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(300)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(60,541)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(833)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(56,361)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (159,389)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(373,841)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (373,841)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (533,230)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Willow Crest Nsg. Pavilion

ID# 0036533

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Loss on Disposal of Assets	$ (3,623)	21	1
2	Discounts Earned	(944)	21	2
3	Bank Charges	(115)	21	3
4	COPE Dues	(1,133)	20	4
5	Capitalized R&M	(2,658)	6	5
6	PPA - Nursing Supplies	(69)	10	6
7	PPA - Employee Benefits	(508)	22	7
8	PPA - Other Professional Fees	(74)	19	8
9	PPA - Radiology	(8,480)	39	9
10	PPA - Insurance	(6,621)	26	10
11	Marketing Salary	(23,292)	43	11
12	Building Company - Franchise Tax	(250)	21	12
13	Building Company - State Replacement Tax	(3,551)	21	13
14	Building Company - Accounting Fees	(600)	19	14
15	Building Company - Amortization	(3,350)	31	15
16	Marketing - Travel Expense	(1,093)	25	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
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32				32
33				33
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35				35
36				36
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90				90
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93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(56,361)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(391)											(391)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			770									770	5
6	Maintenance	(2,658)		1,570	5,842								4,754	6
7	Other (specify):*					492							492	7
8	**TOTAL General Services**	(3,049)		2,340	5,842	492							5,625	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(69)						(629)					(698)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(69)						(629)					(698)	16
	C. General Administration													
17	Administrative			(49,000)	90,880								41,880	17
18	Directors Fees													18
19	Professional Services	(674)	600	(243,564)									(243,638)	19
20	Fees, Subscriptions & Promotions	(61,974)		436									(61,538)	20
21	Clerical & General Office Expenses	(9,316)	3,801	32,324	5,647								32,456	21
22	Employee Benefits & Payroll Taxes	(508)											(508)	22
23	Inservice Training & Education													23
24	Travel and Seminar			448									448	24
25	Other Admin. Staff Transportation	(1,093)											(1,093)	25
26	Insurance-Prop.Liab.Malpractice	(6,621)		1,399									(5,222)	26
27	Other (specify):*			5,734		16,411							22,145	27
28	**TOTAL General Administration**	(80,186)	4,401	(252,223)	96,527	16,411							(215,070)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(83,304)	4,401	(249,883)	102,369	16,903		(629)					(210,143)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Willow Crest Nsg. Pavilion** **#** **0036533** **Report Period Beginning:** **01/01/04** **Ending:** **12/31/04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(26,357)	100,697	2,554									76,894	30
31	Amortization of Pre-Op. & Org.	(3,350)	3,350											31
32	Interest	(14,606)	115,950	2,205									103,549	32
33	Real Estate Taxes			2,732									2,732	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			5,684									5,684	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(44,313)	(260,003)	13,175									(291,141)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(8,480)						(174)					(8,654)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(23,292)											(23,292)	43
44	**TOTAL Special Cost Centers**	(31,772)						(174)					(31,946)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(159,389)	(255,602)	(236,708)	102,369	16,903		(803)					(533,230)	45

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Willow Crest Bldg LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 480,000	Willow Crest Building LLC		$	$ (480,000)	1
2	V	32	Interest Income	410				(410)	2
3	V	32	Interest Expense				116,360	116,360	3
4	V	21	Franchise Tax				250	250	4
5	V	21	State Replacement Tax				3,551	3,551	5
6	V	19	Accounting Fees				600	600	6
7	V	30	Depreciation Expense				100,697	100,697	7
8	V	31	Amortization - Mortgage Costs				3,350	3,350	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 480,410			$ 224,808	$ * (255,602)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 770	$ 770	15
16	V	6	REPAIRS & MAINT.				1,570	1,570	16
17	V	19	PROFESSIONAL FEES				1,550	1,550	17
18	V	20	DUES AND SUBSCRIPTIONS				436	436	18
19	V	21	CLERICAL & GENERAL				32,324	32,324	19
20	V	24	SEMINARS AND TRAVEL				448	448	20
21	V	26	INSURANCE				1,399	1,399	21
22	V	27	EMP.BEN. - GEN. ADMIN.				5,734	5,734	22
23	V	30	DEPRECIATION				2,554	2,554	23
24	V	32	INTEREST				2,205	2,205	24
25	V	33	REAL ESTATE TAXES				2,732	2,732	25
26	V	35	EQUIPMENT RENTAL				5,684	5,684	26
27	V								27
28	V	19	BOOKKEEPING SERVICES	245,114				(245,114)	28
29	V	17	MANAGEMENT FEES	49,000				(49,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 294,114			$ 57,406	$ * (236,708)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 5,842	$ 5,842	15
16	V	17	ADMIN. CMP. - M. MAUER				13,728	13,728	16
17	V	17	ADMIN. CMP. - M. AARON				15,176	15,176	17
18	V	17	ADMIN. CMP. - F. AARON				19,005	19,005	18
19	V	17	ADMIN. CMP. - S. GOLDSTEIN						19
20	V	17	ADMIN. CMP. - S. KOPLIN				8,802	8,802	20
21	V	17	ADMIN. CMP. - D. MAGAFAS				7,180	7,180	21
22	V	17	ADMIN. CMP. - S. LEVY				12,298	12,298	22
23	V	17	ADMIN. CMP. - HOWARD ALTER						23
24	V	17	ADMIN. CMP. - NON-OWNER				14,691	14,691	24
25	V	21	CLERICAL CMP. - S. AARON				5,647	5,647	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 102,369	$ * 102,369	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 492	$ 492	15
16	V	27	EMP. BEN.- M. MAUER				1,113	1,113	16
17	V	27	EMP. BEN.- M. AARON				1,676	1,676	17
18	V	27	EMP. BEN.- F. AARON				5,450	5,450	18
19	V	27	EMP. BEN.- S. GOLDSTEIN						19
20	V	27	EMP. BEN.- S. KOPLIN				2,618	2,618	20
21	V	27	EMP. BEN.- D. MAGAFAS				677	677	21
22	V	27	EMP. BEN.- S. LEVY				1,719	1,719	22
23	V	27	EMP. BEN.- HOWARD ALTER						23
24	V	27	EMP. BEN.- NON-OWNER				2,186	2,186	24
25	V	27	EMP. BEN. - S. AARON				972	972	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 16,903	$ * 16,903	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY	$	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	$	$	15
16	V	19	PROFESSIONAL FEES	7,170	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	7,170		16
17	V	22	EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			17
18	V	39	ANCILLARY SERVICES		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,170			$ 7,170	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V	10	MEDICAL SUPPLIES	3,343	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	2,714	(629)	16
17	V	39	ANCILLARY EXPENSE	923	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	749	(174)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,266			$ 3,463	$ * (803)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Maurice Aaron	Owner	Administrative	23.79%	see attached	3.57	7.14%	Dynamic	$ 15,176	17-07	1
2	Marshall Mauer	Owner	Administrative	10.78%	see attached	3.23	6.46%	Dynamic	13,728	17-07	2
3	Fred Aaron	Owner	Administrative	13.10%	see attached	7.50	15.96%	Dynamic/Sal	35,505	17-01,17-07	3
4	Diania Magafas	Owner	Administrative	0.56%	see attached	4.02	8.94%	Dynamic/Sal	9,980	17-01,17-07	4
5	Dennis Nehmer	Owner	Maintenance	0.56%	see attached	3.57	8.94%	Dynamic	5,842	6-07	5
6	Sue Koplin	Owner	Administrative	0.56%	see attached	4.84	12.09%	Dynamic	8,802	17-07	6
7	Sharon Aaron	Owner	Clerical	0.56%	see attached	3.23	8.08%	Dynamic	5,647	21-07	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 94,680		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	427,864	12	$ 9,658	$	34,128	$ 770	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	427,864	12	19,683		34,128	1,570	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	427,864	12	19,431		34,128	1,550	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	427,864	12	5,469		34,128	436	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	427,864	12	405,253	290,672	34,128	32,324	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	427,864	12	5,616		34,128	448	6
7	26	INSURANCE	PATIENT DAYS	427,864	12	17,537		34,128	1,399	7
8	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	427,864	12	71,885		34,128	5,734	8
9	30	DEPRECIATION	PATIENT DAYS	427,864	12	32,025		34,128	2,554	9
10	32	INTEREST	PATIENT DAYS	427,864	12	27,646		34,128	2,205	10
11	33	REAL ESTATE TAXES	PATIENT DAYS	427,864	12	34,248		34,128	2,732	11
12	35	EQUIPMENT RENTAL	PATIENT DAYS	427,864	12	71,259		34,128	5,684	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 719,710	$ 290,672		$ 57,406	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	65,436	65,436	3.57	5,842	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	170,000	170,000	3.23	13,728	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	170,000	170,000	3.57	15,176	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	47	6	119,100	119,100	7.50	19,005	4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	24,000	24,000			5
6	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	7	72,815	72,815	4.84	8,802	6
7	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	80,395	80,395	4.02	7,180	7
8	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	11	152,350	152,350	3.63	12,298	8
9	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			9
10	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	9	164,490	164,490	4.02	14,691	10
11	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	69,932	69,932	3.23	5,647	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,100,518	$ 1,100,517		$ 102,369	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	5,508		3.57	492	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	13,783		3.23	1,113	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	18,779		3.57	1,676	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	47	6	34,154		7.50	5,450	4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	25,404				5
6	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	7	21,655		4.84	2,618	6
7	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	7,575		4.02	677	7
8	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	11	21,295		3.63	1,719	8
9	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,244				9
10	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	9	24,475		4.02	2,186	10
11	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	12,038		3.23	972	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 185,910	$		$ 16,903	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS, L.L.C.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION							1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION						7,170	2
3	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							3
4	39	ANCILLARY SERVICES	DIRECT ALLOCATION							4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 7,170	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						2,714	2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						749	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 3,463	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Ford Credit		X	Van			$	$ 48,452			$ 1,260	1
2	Bank One		X	Mortgage			3,350,000	1,618,234			116,360	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Bank One		X	Line of Credit				100,000			15,371	6
7	Diamond Insurance		X	Liability Insurance Funding							1,874	7
8	See Supplemental Schedule										2,205	8
9	TOTAL Facility Related						$ 3,350,000	$ 1,766,686			$ 137,070	9
	B. Non-Facility Related*											
10	Interest Income										(14,606)	10
11	Interest Income (Bldg Co.)										(410)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (15,016)	14
15	TOTALS (line 9+line14)						$ 3,350,000	$ 1,766,686			$ 122,054	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc from Dynamic		X				$	$			$ 2,205	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										2,205	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	63,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	62,120	2
3. Under or (over) accrual (line 2 minus line 1).	$	(880)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	61,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5,000	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	65,120	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	49,489	8
	2000	50,345	9
	2001	52,352	10
	2002	60,439	11
	2003	59,388	12

2004 Accrual = 2003 Tax $59,388 x 1.03 = $61,000 (rounded)

Allocation from Dynamic $2732

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Crest Nsg. Pavilion COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-26-433-024	Long Term Care Property	$ 59,387.92	$ 59,387.92
2.	See Attached	Home Office Allocation	$ 30,261.49	$ 2,413.77
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 89,649.41	$ 61,801.69

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Crest Nsg. Pavilion COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,430 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1998	$ 327,859	1
2					2
3	TOTALS			$ 327,859	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	21,410		20	1,071	1,071	15,527	9
10	Various			1991	9,997		20	-		9,918	10
11	Various			1992	4,279		20	214	214	2,684	11
12	Various			1993	26,868		20	1,344	(1,344)	15,286	12
13	Various			1994	8,312		20	416	416	4,384	13
14	Various			1995	3,234		20	162	162	1,544	14
15	Various			1996	17,411		20	870	870	7,110	15
16	Various			1997	68,499		20	3,425	3,425	24,089	16
17	Various			1998	31,645		20	1,583	1,583	9,872	17
18	Various			1999	147,088		20	7,299	7,299	39,958	18
19	Various			2000	149,982		20	7,501	7,501	34,132	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,544,733	65,250		65,250		391,219	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		35,383	907		1,011	104	11,457	68
69	Financial Statement Depreciation			25,795			(25,795)		69
70	TOTAL (lines 4 thru 69)		$ 3,068,841	$ 91,952		$ 90,146	$ (4,494)	$ 567,180	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,068,841	$ 91,952		$ 90,146	$ (1,806)	$ 567,180	1
2	Remodel Stairwell	2001	1,080		20	54	54	180	2
3	Doors & Refinishing	2001	13,510		20	676	676	2,365	3
4	Doors & Refinishing	2001	1,725		20	86	86	295	4
5	Doors & Refinishing	2001	100		20	5	5	17	5
6	Doors & Refinishing	2001	1,925		20	96	96	329	6
7	Doors & Refinishing	2001	900		20	45	45	154	7
8	Doors & Refinishing	2001	300		20	15	15	50	8
9	Doors & Refinishing	2001	300		20	15	15	50	9
10	Doors & Refinishing	2001	1,300		20	65	65	217	10
11	Doors & Refinishing	2001	900		20	45	45	150	11
12	Doors & Refinishing	2001	600		20	30	30	100	12
13	Bathroom Imprvmnt	2001	641		20	32	32	109	13
14	Dining Rm Tile	2001	720		20	36	36	123	14
15	Bathroom Faucet	2001	725		20	36	36	124	15
16	Bathroom Fixtures	2001	2,434		20	122	122	416	16
17	Drywall Mat'L For 2F	2001	375		20	19	19	64	17
18	Door Frame	2001	315		20	16	16	54	18
19	Tile	2001	424		20	21	21	73	19
20	Doors	2001	1,096		20	55	55	187	20
21	Door Hinges	2001	237		20	12	12	41	21
22	Doors	2001	392		20	20	20	67	22
23	Tile	2001	198		20	10	10	34	23
24	Bathroom Fixtures	2001	228		20	11	11	39	24
25	Bathroom Fixtures	2001	821		20	41	41	140	25
26	Bathroom Floor	2001	1,610		20	81	81	269	26
27	Wall Guard	2001	715		20	36	36	119	27
28	Wall Covering	2001	3,920		20	196	196	653	28
29	Bathroom Floor	2001	3,283		20	164	164	547	29
30	Light Fixtures	2001	337		20	17	17	57	30
31	Bathroom Fixtures	2001	407		20	20	20	68	31
32	Bathroom Fixtures	2001	350		20	18	18	59	32
33	Door	2001	495		20	25	25	89	33
34	TOTAL (lines 1 thru 33)		$ 3,111,204	$ 91,952		$ 92,266	$ 314	$ 574,419	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,111,204	$ 91,952		$ 92,266	$ 314	$ 574,419	1
2	Door	2001	42		20	2	2	7	2
3	Door	2001	171		20	9	9	31	3
4	Repair Concrete In R	2001	260		20	13	13	46	4
5	Carpet For Rehab Rm	2001	493		20	25	25	87	5
6	Repair Ifre Alarm Sy	2001	633		20	32	32	111	6
7	Fixtures For Rehab R	2001	192		20	10	10	34	7
8	Door Locks	2001	367		20	18	18	64	8
9	Fixtures For Rehab	2001	170		20	9	9	31	9
10	Fixtures For Rehab R	2001	527		20	26	26	92	10
11	Fixtures For Rehab R	2001	407		20	20	20	71	11
12	Door Frames	2001	315		20	16	16	55	12
13	Ceiling Tile	2001	170		20	9	9	31	13
14	Kick Plates For Drs	2001	1,591		20	80	80	279	14
15	Nurses Station	2001	9,066		20	453	453	1,587	15
16	Fixtures	2001	408		20	20	20	71	16
17	Bathroom Floor	2001	1,375		20	69	69	235	17
18	Wood Strips For Ther	2001	3,929		20	196	196	671	18
19	Carpeting	2001	547		20	27	27	93	19
20	Repair Of Water Soft	2001	2,418		20	121	121	484	20
21	Door	2001	1,295		20	65	65	254	21
22	Repair Water Heater	2001	1,956		20	98	98	383	22
23	Flooring	2001	2,104		20	105	105	412	23
24	Flooring	2001	2,517		20	126	126	494	24
25	Install Magnetics Lo	2001	589		20	29	29	110	25
26	Doors	2001	328		20	16	16	61	26
27	Store Room Lock	2001	216		20	11	11	40	27
28	Door Handles	2001	309		20	15	15	57	28
29	Door Handles	2001	141		20	7	7	26	29
30	Shelves	2001	717		20	36	36	135	30
31	Nurses Station	2001	9,066		20	453	453	1,662	31
32	Shelving	2001	480		20	24	24	88	32
33	Door Kick Plates	2001	229		20	11	11	41	33
34	TOTAL (lines 1 thru 33)		$ 3,154,232	$ 91,952		$ 94,417	$ 2,465	$ 582,262	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,154,232	$ 91,952		$ 94,417	$ 2,465	$ 582,262	1
2	Doors	2001	1,025		20	51	51	188	2
3	Drywall Halls, New C	2001	2,650		20	133	133	487	3
4	Stain For Doors	2001	228		20	11	11	41	4
5	Signs	2001	744		20	37	37	134	5
6	Custom Wall Cabinets	2001	9,266		20	463	463	1,660	6
7	Doors	2001	429		20	21	21	76	7
8	Woodstrips	2001	268		20	13	13	43	8
9	Wallpaper	2001	1,980		20	99	99	322	9
10	Foot Rails	2001	1,962		20	98	98	319	10
11	Wallcovering	2001	2,793		20	140	140	454	11
12	Wallpaper	2001	4,500		20	225	225	731	12
13	2Nd Floor Bulbs	2001	195		20	10	10	32	13
14	Doors & Refinishing	2001	1,500		20	75	75	244	14
15	Signs	2001	1,938		20	97	97	307	15
16	Wallpaper & Plaster	2001	3,400		20	170	170	538	16
17	Elevator Voice Activ	2001	1,500		20	75	75	238	17
18	Door Locks	2001	1,705		20	85	85	270	18
19	Door Wiring	2001	3,000		20	150	150	463	19
20	Remodeling - 2Fl	2001	13,885		20	694	694	2,141	20
21	Plumbing	2001	867		20	43	43	166	21
22	Carpeting	2002	15,541		20	2,220	2,220	6,475	22
23	Temperature Control	2002	627		20	63	63	178	23
24	Temperature Switch	2002	560		20	56	56	159	24
25	Monitoring Panel	2002	937		20	94	94	265	25
26	Tiling	2002	963		20	48	48	132	26
27	Wallpaper	2002	8,570		20			8,570	27
28	Wallcovering	2002	1,182		20			1,182	28
29	Ceiling Tile	2002	919		20	46	46	126	29
30	Storage Tank	2002	2,199		20	220	220	605	30
31	Kitchen Lights	2002	1,124		20	112	112	300	31
32	Cove Base	2002	728		20	73	73	194	32
33	Wall Mount Cooler	2002	530		20	53	53	137	33
34	TOTAL (lines 1 thru 33)		$ 3,241,947	$ 91,952		$ 100,092	$ 8,140	$ 609,439	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,241,947	$ 91,952		$ 100,092	$ 8,140	$ 609,439	1
2	Smoke Detector	2002	1,872		20	187	187	468	2
3	Doors	2002	1,289		20	64	64	150	3
4	Lighting	2002	352		20	35	35	82	4
5	Lighting	2002	517		20	52	52	121	5
6	Roofing	2002	4,265		20	427	427	1,031	6
7	Wall Heaters & A/C	2002	5,259		20	526	526	1,227	7
8	Light Fixtures	2002	1,132		20	113	113	236	8
9	Heating	2002	588		20	59	59	147	9
10	Fire Alarm System	2002	730		20	104	104	304	10
11	Alarm System Repair	2002	563		20	80	80	221	11
12	Alarm System Repair	2002	563		20	80	80	221	12
13	Heating	2002	586		20	59	59	147	13
14	Phone System	2002	510		20	51	51	153	14
15	Walk-In Cooler And Condensing Unit	2003	3,589		20	359	359	688	15
16	Roof Repairs	2003	2,480		20	248	248	434	16
17	Custom Built-In Wardrobe Dresser Units	2003	63,420		20	6,342	6,342	10,042	17
18	Elevator Handrails, Window Treatments & Curtains	2003	6,476		20	648	648	971	18
19	Sealcoating Parking Lot	2003	2,250		20	225	225	300	19
20	Hot Water System	2003	1,387		20	139	139	173	20
21	Elevator Work	2004	11,800		20	1,180	1,180	1,180	21
22	2Nd Floor Bathroom Improvment	2004	2,654		20	221	221	221	22
23	Improvements On Resident Room	2004	4,427		20	332	332	332	23
24	Scalcoating And Striping	2004	2,250		20	150	150	150	24
25	New Dynalock	2004	1,460		20	85	85	85	25
26	Air Conditioner	2004	1,753		20	58	58	58	26
27	Air Conditioner Unit	2004	1,753		20	175	175	175	27
28	Back Door	2004	1,190		20	119	119	119	28
29	Bathroom Remodeling	2004	1,701		20	156	156	156	29
30	Toilet And Supplies	2004	452		20	38	38	38	30
31	Toilets	2004	310		20	26	26	26	31
32	2Nd Floor Bathroom Supplies	2004	260		20	22	22	22	32
33	2Nd Floor Bathroom Supplies	2004	3,817		20	318	318	318	33
34	TOTAL (lines 1 thru 33)		$ 3,373,602	$ 91,952		$ 112,770	$ 20,818	$ 629,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,373,602	$ 91,952		$ 112,770	$ 20,818	$ 629,435	1
2	2Nd Floor Bathroom Supplies	2004	149		20	12	12	12	2
3	2Nd Floor Bathroom Supplies	2004	136		20	11	11	11	3
4	2Nd Floor Bathroom Supplies	2004	809		20	67	67	67	4
5	Tile & Fix Walls In Bathroom	2004	4,050		20	338	338	338	5
6	Roof Repairs	2004	7,375		20	615	615	615	6
7	Tile & Fix Walls In Bathrooms	2004	4,275		20	321	321	321	7
8	Fittings And Pipe For Water Main	2004	924		20	62	62	62	8
9	Shed	2004	954		20	24	24	24	9
10	Exit Alarm & Fall Monitor	2004	795		20	7	7	7	10
11	Exit Alarm & Fall Monitor	2004	900		20	8	8	8	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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23									23
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,393,969	$ 91,952		$ 114,235	$ 22,283	$ 630,900	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,393,969	$ 91,952		$ 114,235	$ 22,283	$ 630,900	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,393,969	$ 91,952		$ 114,235	$ 22,283	$ 630,900	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,393,969	$ 91,952		$ 114,235	$ 22,283	$ 630,900	1
2									2
3									3
4									4
5									5
6									6
7									7
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9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,393,969	$ 91,952		$ 114,235	$ 22,283	$ 630,900	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,393,969	$ 91,952		$ 114,235	$ 22,283	$ 630,900	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,393,969	$ 91,952		$ 114,235	$ 22,283	$ 630,900	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,393,969	$ 91,952		$ 114,235	$ 22,283	$ 630,900	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,393,969	$ 91,952		$ 114,235	$ 22,283	$ 630,900	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 3,393,969	$ 91,952		$ 114,235	$ 22,283	$ 630,900	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,393,969	$ 91,952		$ 114,235	$ 22,283	$ 630,900	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	116		1998		$ 2,544,733	$ 65,250		$ 65,250	$	$ 391,219	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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10											10
11											11
12											12
13											13
14											14
15											15
16											16
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30											30
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32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,544,733	$ 65,250		$ 65,250	$	$ 391,219	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Dynamic		1993		$ 35,383	$ 907		$ 1,011	$ 104	$ 11,457	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 35,383	$ 907		$ 1,011	$ 104	$ 11,457	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 869,775	$ 69,732	$ 91,764	$ 22,032	10	$ 636,924	71
72	Current Year Purchases	32,961	31,905	4,107	(27,798)	10	4,107	72
73	Fully Depreciated Assets	49,890				10	49,889	73
74								74
75	TOTALS	$ 952,626	$ 101,637	$ 95,871	$ (5,766)		$ 690,920	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	DODGE WAGON	1994	$	$ 1,675	$ 1,606	$ (69)		$	76
77	Facility	BUS	2004	44,500	44,500	2,119	(42,381)	5	2,119	77
78		Dynamic Allocation		4,490	513	89	(424)	5	4,490	78
79										79
80	TOTALS			$ 48,990	$ 46,688	$ 3,814	$ (42,874)		$ 6,609	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,723,444	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 240,277	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 213,920	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (26,357)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,328,429	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 4,364 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation from Dynamic		$	$ 5,614	17
18					18
19					19
20					20
21	TOTAL		$	$ 5,614	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 01	hrs	$ 56,329		$	$		$ 56,329	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	10,444					10,444	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	75,327					75,327	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				106,364		106,364	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						28,015		28,015	13
14	TOTAL			$ 142,100		$	$ 134,379		$ 276,479	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 47,216	$ 117,102	1
2	Cash-Patient Deposits	42,190	42,190	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	688,676	688,676	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,810	28,810	6
7	Other Prepaid Expenses	10,897	10,897	7
8	Accounts Receivable (owners or related parties)	131,105	233,705	8
9	Other(specify): See Attached Schedule	9,961	2,942	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 958,855	$ 1,124,322	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		327,859	13
14	Buildings, at Historical Cost		2,544,733	14
15	Leasehold Improvements, at Historical Cost	774,535	774,535	15
16	Equipment, at Historical Cost	572,781	978,781	16
17	Accumulated Depreciation (book methods)	(684,284)	(1,453,486)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,000	6,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,000)	(6,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		13,260	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 663,032	$ 3,185,682	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,621,887	$ 4,310,004	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 170,138	$ 170,138	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,747	44,747	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	184,714	184,714	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,810	2,810	31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,000	61,000	32
33	Accrued Interest Payable	1,357	7,442	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,005	9,005	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	31,000	31,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 504,771	$ 510,856	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	148,452	148,452	39
40	Mortgage Payable		1,618,234	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 148,452	$ 1,766,686	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 653,223	$ 2,277,542	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 968,664	$ 2,032,462	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,621,887	$ 4,310,004	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 656,722	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 656,722	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	323,542	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(11,600)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 311,942	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 968,664	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,584,116	1
2	Discounts and Allowances for all Levels	(975,955)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,608,161	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	794,800	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 794,800	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	159,545	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,439	19
20	Radiology and X-Ray	3,589	20
21	Other Medical Services	15,311	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 202,884	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,606	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,606	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	944	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 944	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,621,395	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	755,843	31
32	Health Care	1,547,161	32
33	General Administration	934,180	33
	B. Capital Expense		
34	Ownership	697,214	34
	C. Ancillary Expense		
35	Special Cost Centers	299,771	35
36	Provider Participation Fee	63,684	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,297,853	40
41	**Income before Income Taxes (line 30 minus line 40)****	323,542	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 323,542	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,882	2,091	$ 49,786	$ 23.81	1
2	Assistant Director of Nursing	718	849	23,286	27.43	2
3	Registered Nurses	9,098	9,768	227,611	23.30	3
4	Licensed Practical Nurses	15,531	16,681	366,077	21.95	4
5	Nurse Aides & Orderlies	51,031	53,051	596,551	11.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,859	5,122	142,100	27.74	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,749	1,946	25,406	13.06	9
10	Activity Assistants	4,770	4,964	32,905	6.63	10
11	Social Service Workers	3,283	3,399	44,392	13.06	11
12	Dietician					12
13	Food Service Supervisor	1,728	1,967	30,122	15.31	13
14	Head Cook	3,517	3,742	42,442	11.34	14
15	Cook Helpers/Assistants	14,102	14,819	105,971	7.15	15
16	Dishwashers					16
17	Maintenance Workers	3,735	4,112	61,005	14.84	17
18	Housekeepers	10,703	11,384	78,342	6.88	18
19	Laundry	6,905	7,277	43,711	6.01	19
20	Administrator	1,781	2,091	68,879	32.94	20
21	Assistant Administrator					21
22	Other Administrative	599	599	19,350	32.30	22
23	Office Manager					23
24	Clerical	939	1,103	20,586	18.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,194	2,399	27,073	11.29	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	956	1,040	23,292	22.40	33
34	TOTAL (lines 1 - 33)	140,080	148,404	$ 2,028,887 *	$ 13.67	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	245	$ 7,824	01-03	35
36	Medical Director	24	1,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	136	5,400	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	72	3,431	11-03	44
45	Social Service Consultant	32	1,828	12-03	45
46	Other(specify)				46
47	Psycho-Social	7	329	12-03	47
48					48
49	TOTAL (lines 35 - 48)	516	$ 20,012		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	20	$ 756	10-03	50
51	Licensed Practical Nurses	203	7,488	10-03	51
52	Nurse Aides	3,691	82,851	10-03	52
53	TOTAL (lines 50 - 52)	3,914	$ 91,095		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pam Ingold	Administrator	0	$ 68,879
Diania Magafas	Administration	.56	2,800
Fred Aaron	Administration	13.1	16,550
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 88,229

B. Administrative - Other

Description	Amount
Mangement Fees - Dynamic Healthcare	$ 49,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 49,000

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 8,698
Health Data Systems	Data Processing	4,286
Real Estate Anaylsis Corp.	Appraisal (RE Tax Appeal)	5,000
Personnel Planners	Unemployment Consultant	1,019
Econocare	Purchasing Consultant	2,088
Dynamic Rehab Consultants	Billing & Bookkeeping	7,170
Dynamic Healthcare	Billing & Bookkeeping	245,114
Other Professional Fees	Prior Period Adj (adj p. 5)	74
Sachnoff & Weaver Ltd	Legal	13,270
Seyfarth Shaw	Legal	21,749
Robinson & Associates	Computer Services	1,530
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 309,998

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,672
Unemployment Compensation Insurance	27,521
FICA Taxes	154,142
Employee Health Insurance	30,295
Employee Meals	16,013
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	8,474
TOTAL (agree to Schedule V, line 22, col.8)	$ 292,117

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,727
Health Care Worker Background Check	
(Indicate # of checks performed 1)	10
Advertising & Promotion	60,541
Dues & Subscriptions	5,537
Licenses & Permits	2,275
Allocation from Dynamic Consultants	436
Less: Public Relations Expense	( )
Non-allowable advertising	(60,541)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,985

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,584
Prior Period Adjustment	(474)
Allocated from Dynamic Consultants	448
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,558

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg. Pavilion # 0036533 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $6,083**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **895** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **63,684**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **16,013** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.